been in excellent health until six months previously when obscure paroxysmal pain was noted in the left side of the abdomen with soreness there which eventually spread over the whole abdomen. For some weeks before admission the appetite gradually failed and there was progressive loss of flesh and strength. The bowels were regular and there was no diarrhœa. Upon admission there was some fulness of the abdomen with slight tenderness more particularly over the right side. On May 10th, 1900, Dr. Bell made an exploratory incision and found the omentum adherent to the parietes and studded with numerous partly caseating small areas or nodules. There was a reddish but otherwise clear fluid in the pelvis which was mopped out. Owing to the extensive adhesions and the absence of any sign of acute perforation, nothing further was done beyond placing a drainage tube. After the operation the patient did not recover strength and gradually failing she died on the 17th.

At the autopsy the thoracic organs were healthy looking and there were no signs of tuberculosis, unless a slight puckering of the left apex might be considered as such. The condition was apparently confined to the abdomen. Here all the intestines were matted together and adherent to the parietes by rather loose, dirty looking adhesions throughout which, over the surface of the intestine, more especially in the lower quadrant, were very numerous, whitish, irregular little patches, some of which had a shaggy, villous appearance. They varied in size and differed from ordinary new growths in that their centres were apt to be broken down. They differed from ordinary tubercles again in that their centres were more purulent than caseous. The intestines were removed *en masse* and opened *in situ*. Almost from the beginning of the jejunum was a remarkable ulcerative condition of the gut. Every two or three inches was a perforation, about three to four mm. across, through the greatly atrophied wall of the intestine. The walls of the perforations were absolutely clean cut. Examining the organ from the serous surface, each of these perforations corresponded with one of the nodular masses found there. On more careful examination of the serous coat over the jejunum and ileum, *incomplete ulcers could be seen, the serosa being destroyed, the mucosa not yet invaded.*

That the ulceration was from without inwards in this case was further shown by the fact that in the jejunum some of the ulcerations were bridged over by one of the rugæ. Another remarkable point was that there was no fluid in the peritoneal cavity and although there were so many perforations, obviously the dense matting together of the intestines had prevented the development of a generalised perforative peritonitis. To a less extent the condition affected the trans-